# Accessibility to Spa Experiences

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## ABSTRACT

*This chapter aims to highlight and raise awareness of the previously unknown barriers currently faced by wheelchair using consumers in the spa industry and the implications of these barriers for consumer and industry alike. Existing research on accessibility within this specific environment is extremely limited (if any). This study shows that access to accurate information is a key issue, a key barrier to participation and not only for those who have not visited a spa before. Gaining information pre visit in tourism is increasingly done online (Liu et al., 2019) and there is the opportunity to use technologies and especially websites and social media platforms to help provide this information.*

*The chapter also illustrates the potential for health and greater mental and social wellbeing the spa industry and the wider wellness tourism industry have for wheelchair users and how they could mutually benefit each other, as well as further promoting the case for barrier free accessible tourism and leisure opportunities.*

Keywords: Accessibility, Disability, Wheelchair Users, Mobility Impairment, Spa, Wellness, Well-Being

## INTRODUCTION AND CONTEXT OF STUDY

Despite a higher social conscience dictating global policy on disability, intended to promote acceptance and equality (United Nations, 2006a; 2006b), disabled people face widespread discrimination and a diverse range of disabling barriers to participation in everyday life (Gray, Gould, & Bickenbach, 2003; Harpur, Connolly, & Blanck, 2017; World Health Organisation, 2017). With calls from industry, academia and disabled people themselves for better understanding of the experiences and specific needs of this growing demographic of consumer (Jackson, 2018; Tarasoff, 2017; Williams, 2017), the importance of undertaking research on this subject is becoming increasingly apparent; particularly in a world facing the implications of increased life expectancies (Kasnauskiene & Michnevic, 2017) and ageing populations (Buhalis & Darcy, 2011).

The disabled population is projected to steadily increase, with disability and inclusion considered a growing social concern globally (Michopoulou, Darcy, Ambrose, & Buhalis, 2015). Yet much of the traditional thinking and policy making around disability has led to the inadequate physical and social environment that exists today. Modern thinking now views disability as a social construct (Masala & Petretto, 2008) caused and/or exacerbated by a disabling environment (Bogart, Rottenstein, Lund, & Bouchard, 2017; Haegele & Hodge, 2016) and not by placing the disabled person at fault (Masala & Petretto, 2008). Social action and responsibility are needed to change this disabling environment into an enabling environment, ensuring full and equal participation in life as those who are able bodied, minimising the impact of impairment and enabling those who are disabled to enjoy a full and meaningful life as possible (Jackson, 2018).

Tourism and its sub sectors are a key area in which a disabled person can escape daily life and enjoy experiences with loved ones in new and exciting locations, giving a sense of freedom and helping to minimise the effects of mobility impairment (Kaganek et al., 2017; Kastenholz, Eusebio, & Figueiredo, 2015). However, disabling barriers often limit and adversely affect these experiences (Kaganek et al., 2017; Smith, 1987; Yau, McKercher, & Packer, 2004).

Disability and inclusion are becoming progressively more important factors as part of the supply and demand of the tourism industry, with the disabled being recognised as an important consumer demographic and considered vital for tourism economic growth (Ambrose, Darcy, & Buhalis, 2012). Many of the most lucrative travel markets are from developed countries who are experiencing ageing populations with sizeable disposable incomes, yet who are more prone to disability as they age further and will therefore have increasingly more complex and specific needs as a tourism consumer (Darcy & Dickson, 2009; Global Wellness Institute, 2018b). This is a particularly pressing concern for operators of wellness tourism (Crismariu, 2017; Morris, Mueller, & Jones, 2010) of which the spa industry is a key component of, as ageing baby boomers are its key consumer. Wellness tourism, and spa in particular can bring numerous health and wellbeing benefits for wheelchair users, by the diverse therapies and unique experiences they offer (Gomez et al., 2013; Ortega et al., 2017; Suarez et al., 2011).

These industries and institutions will need to be ready to receive future consumers with access needs, and there is an urgent need to implement accessible tourism practices for better and more equal inclusion. This can be achieved by firstly gaining a greater understanding of their complex needs and consumer experiences, in order to improve the current offering. Hence, building on the above discussions, this study investigates the barriers to and within the

spa industry currently encountered by wheelchair consumers, and considers the ability of the industry to service this important and growing tourist market segment. In particular, the objectives of the study are to: (1) understand the barriers to participation wheelchair tourists who have not visited a spa may face; (2) identify the barriers currently encountered by wheelchair tourists during the spa customer journey; and (3) consider how these barriers affect their participation in the spa experience.

## THEORETICAL BACKGROUND

The study was focused on identifying disabling barriers, and therefore it adopts the social model stance on disability, where disability manifests as a result of shortcomings and barriers occurring in a disabling society, not as a result of a person's medical condition or impairment (Haegele & Hodge, 2016). Removal of these barriers therefore lessens the extent of a person's disability. As the study also focused on the impacts of these barriers to social participation, it acknowledges elements of the ICF model (Johnson-Migalski and Drout, 2018) which better highlights the multifaceted nature of disability beyond impairment. It considers external barriers, and also includes personal factors such as how differences in impairment can affect an individual's activity and participation in everyday life situations beyond employment.

Barriers are obstacles which compromise a person's independence and can negatively affect their ability to participate in physical and community activities, limiting freedom and personal control (Harris, Yang, & Sanford, 2015; Kaganek et al., 2017). Participation, especially for those disabled people with a spinal cord injury (SCI) has been found to have a direct and powerful influence on their quality of life, so it can be argued that these barriers not only affect the participation of an experience in the short term, but can gradually have an accumulative effect on a person's life overall (Chang, Wang, Jang, & Wang, 2012).

Across academic literature there are various descriptions for barrier types, however this study focuses on environmental (in this case meaning physical), informational and social barriers. This is because of how they can affect wheelchair users (people with other impairments such as visual impairments will face their own specific barriers):

**Environmental** – These are arguably the most disabling barriers for wheelchair users as they physically prevent full participation and enjoyment by restricting access to areas and surroundings. In a world primarily catering for the able bodied person, "environmental" describes architectural and design issues in the

physical world, such as access restricting infrastructure including narrow doorways, steps and steep ramps, lack of appropriate facilities such as disabled toilets and changing rooms, and can also describe hotel bedrooms with unsuitable bed and shower heights. This category also includes natural obstacles such as rocky paths, long grass or exposed tree roots that make it more difficult to manoeuvre a wheelchair over. Combatting environmental barriers can lead to painful or humiliating experiences (McKercher and Darcy, 2018) if the wheelchair user must leave their chair, or just total lack of participation if they are unable to.

**Informational** – These barriers refer to missing or inaccurate access information on websites. Wheelchair users rely on accurate information to inform their purchase decision or intention to visit (Kolodziejczak, 2019); the Internet is a great source of information, however it is often perceived as inaccurate or unreliable (Buhalis & Michopoulou, 2011; Michopoulou & Buhalis, 2013). This barrier category can also describe inaccurate information received from members of staff at an organisation, either in person, or via email or telephone, and can also describe lack of signage with which to locate accessible facilities.

**Social** – This describes poor social attitudes such as rudeness or contempt from the general public or those in public service, such as receptionists or waiting staff.

**Studies of Barriers Encountered By Wheelchair Users**

Research has started to identify barriers encountered by wheelchair users in various industry sectors around the world, most often using qualitative interviews or focus group research in order to fully examine the participants' experiences in detail. It must be noted that experiences of barriers can vary between different countries and cultures, and are of course subjective to each individual wheelchair user based on his/her capabilities, type of wheelchair, severity of impairment and expectations of an experience. Personal values and morals may also heavily influence reactions to social barriers.

Table 1 below, shows a non-exhaustive list of studies, which have identified examples of existing environmental (physical), informational and social barriers across various other industries and sectors:

*Table 1: Environmental, informational and social barriers found in existing literature*

| Industry/sector | Barrier | | |
|---|---|---|---|
| | **Environmental** | **Informational** | **Social** |
| **Transport** | | | |
| **Aviation**<br><br>(Chang & Chen, 2012; Davies & Christie, 2017; Poria. Reichel, & Brandt, 2010; Yau et al., 2004) | • Narrow plane aisles mean wheelchair users may have to leave their chair, increasing their vulnerability.<br>• Inaccessible toilets leading to use of catheters or starving oneself, in order to prevent the need to use the toilet, can lead to humiliating experiences.<br>• Uncomfortable/<br>• Unsuitable cabin seats. | • Poor information on each individual airlines wheelchair policy, both online, on websites and via the telephone.<br><br>• Lack of accurate information when delays and flight changes occur. | • Staff unaware of how to lift the wheelchair user from chair to airline seat.<br><br>• Crew members communicating to wheelchair users as if they also have a cognitive disability e.g. deliberately slowly and loudly.<br><br>• Crew staff responding to accompanying persons regarding information requests, not to the wheelchair user directly. |
| **Healthcare** | | | |
| **Hospitals/healthcare setting**<br><br>(Stillman, Williams, Bertocci, Smalley, & Frost, 2017; Tarasoff, 2017) | • Inaccessible washrooms, examination tables and beds. | • Lack of information on the medical implications of pregnancy and medication on a wheelchair user. | • Poor attitudes such as mocking other nurses when they are assisting a wheelchair user.<br>• Lack of knowledge on lifting a wheelchair user.<br>• Misunderstandings over disability related needs. |
| **Dentistry**<br><br>(Rachid-Kandvani, Nicolau, & Bedos, 2015) | • Heavy doors.<br>• Narrow doorframes.<br>• Cluttered reception areas making manoeuvring a wheelchair difficult.<br>• Inaccessible or unsuitable toilets.<br>• Very high reception desks.<br>• Uncomfortable dental chair. | • Finding accurate accessibility information when searching for a suitable dental practice, online or by phone. | • Staff refusing treatment to wheelchair users via telephone or in practice.<br><br>• Able-bodied people being served first at reception desks.<br><br>• Dental professionals unwilling or unknowledgeable on how to transfer the wheelchair user onto the dental couch |
| **Leisure, recreation and tourism** | | | |
| **Hotels**<br><br>(Poria, Reichel, & Brandt, 2011) | • Furniture within hotel rooms makes manoeuvring a wheelchair difficult.<br>• Narrow and heavy hotel room doors.<br>• Thick carpets are difficult to roll over<br>• The heights of shelves, basins and switches for air conditioning etc are too high. | • Poor signage of accessible features such as a lift.<br><br>• Hotels inaccurately described as accessible on websites when in reality it is not. | • Staff sometimes too helpful or over protective.<br><br>• Staff unsure how to lift the wheelchair user from the wheelchair to a restaurant chair.<br><br>• Staff assuming that a wheelchair user has a cognitive disability – speaking loudly or slowly or just to the person accompanying him/her. |
| **Leisure/tourist attractions**<br><br>(Jackson & Searle, 1985; United Nations, 2006c) | • Parking problems<br>• Uneven paths<br>• Lack of entrance ramps<br>• Inaccessible toilets, cafes, gift shops, information centres | • Lack of accurate and detailed information on accessibility on websites and provisions for wheelchair users | • Staff sometimes too helpful or over protective.<br>• Staff unsure what was expected of them or how to help. |
| **Libraries**<br><br>(Leong & Higgins, 2010) | • Steps at entrances and lack or ramps to enter the building. | • Poor signage for entrance and lift locations. | • Staff unsure what was expected of them or how to help. |
| **Casinos**<br><br>(Wan, 2013) | • Gaming tables too high, need assistance placing chis and reading other peoples' cards. Tall information desk and cashpoint.<br>• Lack of space to manoeuvre<br>• Lack of accessible toilets and lifts<br>• Wheelchair users have to use the alternative entrances as the main entrance is inaccessible | • Lack of signage to the accessible entrance and the toilets. | • Wheelchair users made to feel like they are not the preferred customers of casinos, were told they are not a priority.<br>• Staff lack training in how to speak to people with disabilities, not just wheelchair users, talked to them like they were stupid.<br>• Poor attitudes from other customers blaming them for slow play. |

This table highlights the presence of multiple barriers in a variety of daily life scenarios and activities. Common themes show physical inaccessibility being caused by architectural physical barriers primarily in the form of narrow doorways and steps. The most common information barrier is lack of accessibility information when using technologies such as websites when searching for a suitable premises or venue. Unsolicited staff conduct and lack of knowledge are the most commonly mentioned social barriers. These barriers on their own are enough to adversely affect the experience for the wheelchair user; therefore it can be assumed that when these barriers are experienced in combinations, the experience is even more deeply affected.

An extra barrier to participation to consider is the intrinsic barrier, directly associated with the individuals' own physical, psychological or cognitive condition, and their personal capabilities with it, as opposed to those barriers as previously discussed which are externally imposed upon the individual (Kastenholz et al., 2015; Smith, 1987). Examples of intrinsic barriers can include health conditions, such as chronic pain, where an individual is in so much pain due to their medical condition, that participation is impossible. Physical and psychological dependency is also an intrinsic barrier, particularly for those with a progressive neurological disorder, or a severe SCI resulting in quadriplegia. In these cases, an individual is completely dependent upon another person as their primary care giver in order to be able to participate, if that person is unavailable, the disabled person cannot therefore independently participate. Intrinsic barriers can go beyond the context they are experienced in and can adversely affect intentions to participate in future activities, sometimes resulting in no future participation at all (Kastenholz et al., 2015; Yau et al., 2004). However, these are again subjective and different wheelchair users will have different thresholds as to where these intrinsic barriers start to affect their participation.

## Barriers Faced By Wheelchair Users In The Context Of Tourism Activities

Tourism provides an escape from daily life and its problems, and it is widely accepted that the desire to travel is the same for persons with or without a disability (Yau et al., 2004). Wheelchair users do travel, despite the challenges involved, however they often face the same problems but in new and unfamiliar situations and locations (Kaganek et al., 2017; Yau et al, 2004) with barriers not only restricting their options for activities on their trip, but critically undermining the key components and objectives of tourism and leisure – freedom and escapism (Smith, 1987). Due to the medical model of disability dictating policy for so long, the able-bodied tourist and their capabilities have been prioritised; urban planning and countryside recreation have centred

around the active seeing and mobile body (Aitchison, 2003). For disabled people overall, barriers are one of the many reasons why participation rates in and qualities of experience of tourism are lower than that of the general population (McKercher & Darcy, 2018).

As previously shown in table 1, air travel, a popular and sometimes the only way of reaching destinations, is fraught with multiple barriers and can be a hugely unpleasant and complicated ordeal for wheelchair users. Such negative experiences can lead to the triggering of the intrinsic barrier, where a person feels they are not able to travel due to the stress and effort required (Yau et al., 2004). Access to historic sights while on a trip frequently involve negotiating many - sometimes uneven - steps, and are enjoyed from a vantage point at which to observe them, and therefore those with mobility impairments are immediately at a disadvantage.

Domestic opportunities to socialise and meet new people are often fraught with arguments and stress (Olsen, 2018). A trip to the cinema with friends can also involve unpleasant experiences; often the only place for a wheelchair is at the very front of the auditorium, particularly when stadium style seating is in place (Hammerle, 2005). This results in a painful viewing angle, straining eyes and necks in order to see properly, and splits groups of friends up as those who are able bodied can sit further back at a more comfortable distance (Hammerle, 2005). This does not provide an equally enjoyable experience for wheelchair users, and is not an experience they are likely to want to repeat; another example of a social outing that wheelchair users would be more inclined to decline in future (Hattan, 2004)

Booking concert tickets can be a lengthy and expensive process for those in wheelchairs; disabled access tickets are often more expensive and more complicated to buy than those with no access needs. They are often in very short supply and must be booked well in advance, which means that the option to join friends at short notice is extremely limited (Olsen, 2018). If tickets are successfully pre-booked, areas for wheelchair access are often placed in areas with a poor view of the stage, or in areas where people can stand in front of them. This leads to the disabled person giving up on attending these types of social outings, due to the stress and financial burden, often triggering intrinsic barriers. According to a survey conducted by disability led charity ‘Attitude is Everything’ (2018), more than 80% of deaf and disabled music fans have experienced problems booking tickets to live music events, with one in ten considering legal action over the difficulties they experience when making their ticket purchase. A lack of comprehensive online information (about the venue), and restrictions on purchases such as disabled tickets only available via a phone call, and difficulties acquiring an accompanying carers ticket, were some of the issues raised by survey respondents.

These barriers directly affect participation in activities that should bring joy and relief to a person; instead, they add further difficulty and stress.

**The Case For Accessible Tourism**

In several points of the UN Convention on the Rights of Persons with Disabilities (CRPD) Article 30, it was declared that UN states must take appropriate measures to ensure that those with disabilities enjoy access to places for tourism services, access to tourism venues and access to tourism activities (United Nations, 2006c), encouraging worldwide awareness and the widespread implementation of accessible tourism. The word accessibility when used in a disability context implies that disabled people can, without assistance, reach, enter or pass to and from, and make use of facilities without being made to feel that one is the object of charity (Nyanjom, Boxall, & Slaven, 2018). Accessible tourism therefore describes this inclusive access for disabled people, to tourism products services and environments, including those with permanent or temporary mobility, vision, hearing or cognitive impairments (Darcy & Dickson, 2009), or to put it briefly “tourism for all” (Michopoulou et al., 2015). Tourism New South Wales has added to this definition, by stating that accessible tourism should make it easy for all people to *enjoy* tourism experiences (Darcy & Dickson, 2009). The addition of the word enjoy is key, as one of the key aspects of tourism is fun and recreation; if the experience is not enjoyable then the whole purpose of the excursion is futile.

As well as those with disabilities, other sections of society – estimated as being roughly 31% of a developed countries population - also benefit from accessible tourism (Darcy & Dickson, 2009), including those who are obese, older people and families with young children/toddlers who may also be pushing a buggy. Because of its implications, accessible tourism has been described as a vehicle with which to promote individual and social well-being, not just for socially marginalised groups and their families (disabled people), but for society as a whole (Devile & Kastenholz, 2017).

Accessible tourism is an evolving area, for both industry practice and academia (Buhalis & Darcy, 2011; Devile & Kastenholz, 2017). As more research is conducted into the needs and experiences of those who have access requirements, a greater understanding is achieved with which to lay the foundations in order to direct policy and industry, with the aim to create more inclusive practices within tourism. Removing barriers to achieve accessible tourism for disabled people, unlocks those stimulating and empowering activities as previously discussed, leading to increased participation, improved health and a better quality of life. As well as the individual and social benefits, there are economic advantages of accessible tourism too.

As well as gaining momentum as a pressing human rights issue, accessible tourism is also gaining recognition for its important contribution to the economics of the tourism industry (Ambrose et al., 2012). The Purple Pound describes the spending power of disabled households in the UK, and its contribution to accessible tourism in England alone is worth over £12.1 billion (Visit England, 2015; Williams, 2017). Overall, the value of the Purple Pound in the UK is worth £250 billion (Williams, 2017) making the disabled a consumer group with huge spending potential. Hence, the spending power of the disabled as a consumer group is sizeable, and should be considered by accessible businesses and industries.

**Wellness Tourism and Spa**

Wellness tourism is the area in which the vast tourism and wellness industries overlap. It primarily describes the branch of tourism catering for both health and tourism motivations, where one of the main objectives of taking leisure time away from home is to maintain or improve the state of one's personal health and wellbeing (Clift & Page, 1996; Global Wellness Institute, 2018b). It is one of the fastest growing tourism subsectors (Global Wellness Institute, 2018b), offering unique social leisure experiences each with their own specific health benefits as the name suggests (Michopoulou, 2017), and therefore could be a particularly appealing area of tourism for wheelchair users to explore.

At the turn of the new millennium, it was predicted to be a significant and powerful subsector of the tourism industry (Weiermair & Mathies, 2004) and this prediction was realised; wellness tourism is thriving and growing more than twice as fast as general tourism itself and was worth approximately $639.4 billion in 2017 (Global Wellness Institute, 2018a). A key component of the wellness tourism industry is the $118.8bn spa industry (Global Wellness Institute, 2018a).

Wellness tourism is fuelled by increasingly active, health conscious and wealthy generations, particularly the baby boomers, coupled with younger generations who are becoming more stressed and seeking an escape from fast paced lifestyles and a poor work/life balance (Global Wellness Institute, 2018a; Hudson, Thal, Cardeas, & Meng, 2017; Kim, Chiange, & Tang, 2016; Mintel, 2015; Voigt, Brown, & Howat, 2011). Baby boomers are the most powerful demographic within tourism overall, due to their large numbers and considerable disposable income (Borges Tiago, Couto, Tiago, & Dias Faria, 2016; Hung & Petrick, 2009; Tsiotsou & Hudson, 2010) and are also considered the key wellness tourist responsible for driving the demand of its products and services as they seek out active and fulfilling experiences to preserve and prolong their youth in their retirement years; spa destinations and resorts being

an ideal place of interest in which to achieve this (Darcy & Dickson, 2009; Hung & Lu, 2016; Ozkuk et al., 2018; Voigt & Pforr, 2014).

They are also the demographic of tourist that are the most likely to have disabilities due to accidents or injuries, and experience changes in mental, physical or sensory abilities due to their age (Crismariu, 2017; Morris, Mueller & Jones, 2010). Strokes, diabetes and both osteo and rheumatoid arthritis, give rise to a greater chance of mobility impairment likelihood of needing a wheelchair (Crismariu, 2017; Smith, Sakakibara, & Miller. 2016).

Wellness tourism destinations and facilities will be facing the increased probability of hosting customers who are mobility impaired or wheelchair dependent in the coming years, heightening the need for the adoption of accessible tourism practices within this sector. Making a wellness tourism facility such as a spa accessible and wheelchair friendly has benefits for both parties.

## The Potential Benefits of Spa For Wheelchair Users

As well as being well placed to meet the needs of the health conscious baby boomers, spa visits have also been described as ideal for people living with lifelong disabilities and many of these institutions market themselves on the rejuvenating benefits to be gained from their facilities and treatments (Smith & Puczko, 2017) particularly those in Eastern Europe which take a more clinical spa approach (Rawlinson & Heap, 2017). Table 2 below displays selected spa therapies and their benefits for symptoms of those who may be wheelchair dependent either due to age, injury, or congenital condition:

*Table 2: Potential benefits of spa therapies for wheelchair users*

| Spa therapy | Health benefit |
|---|---|
| Massage | • Lowers heart rate and blood pressure, reducing anxiety and mental fatigue (Beck, 2010)<br>• Powerful sedative, deeply relaxing – promotes sleep (Johnson, 2011; Koog, Jin, Yoon, & Min, 2010)<br>• Pain relief (Keeratitanont, Jensen, Chatchawan, & Auvichayapat, 2015; Peamruetai, et al., 2016; Sritoomma, Moyle, Cooke, & O'Dwyer, 2012;) |
| Thalassotherapy (therapeutic use of seawater/sea air/ sea products/ coastal climate) | • Promotes sleep (Charlier & Chaineaux, 2009; Pereira, 2018)<br>• Effective for dry or inflamed skin disorders, pain relief, anti-depressant and boosts the metabolism and circulation (Pereira, 2018) |
| Pelotherapy (therapeutic use and application of thermal muds/ mud baths/rasul chambers) | • Anti-inflammatory and analgesic (Gomez et al., 2013; Ortega et al., 2017; Suarez et al., 2011).<br>• Stimulates circulation (Gutenbrunner, Bender, Cantista, & Karagulle, 2010) |
| Hydrotherapy/ balneotherapy (therapeutic use of water/mineral water) | • Pain relief for muscles and joints (Karagulle & Karagulle, 2015; Ozkuk et al., 2018; Ucok et al., 2008; Zhang, Roxburgh, Huang, Parsons, & Davies, 2014) |

| | |
|---|---|
| | • Reduces anxiety (Ozkuk et al., 2018)<br>• Beneficial for joint, spinal and mobility conditions (Gass & Gass, 2001; Karagulle & Karagulle, 2015; Ucok et al., 2008; Varga et al., 2008; Zhang et al., 2014) |
| Aromatherapy (therapeutic use of essential oils) | • Deep relaxation (Koog et al., 2010)<br>• Promotes sleep (Domingos & Braga, 2014)<br>• Reduces anxiety (Domingos & Braga, 2014) |

As seen in table 2, it becomes clear that spa therapies offer a range of physical, physiological and psychological benefits. Additionally, the often peaceful and relaxing environment and surroundings of spas, especially those by the coast can calm anxiety, lower blood pressure and promote better sleep (Charlier & Chaineaux, 2009; Global Wellness Summit, 2019). Finally, resort and hotel spas often offer other leisure activities, that may appeal to more active accompanying family members or carers, such as tennis, yoga, golf or cycling, making them an ideal location that offers something for everyone to enjoy.

However, there is little existing knowledge on the barriers that may influence wheelchair users' participation in spa experiences. If a wheelchair user does visit a spa, it is unknown which barriers they encounter and how this affects their customer experience. There is therefore a pressing need to identify and understand both the barriers to participation currently existing that prevent wheelchair users from being able to take part in a spa experience, as well as those that are encountered by a wheelchair user within the spa customer journey. This will allow industry to better accommodate this demographic of spa consumer better, and thus improving their experience, creating value for both parties as well for society at large.

## METHODOLOGY

This exploratory study adopted a qualitative approach and was conducted using a mono-method cross sectional design, allowing collection of information rich data from multiple participants at a single snapshot in time in the UK (Bryman, 2016; Marshall & Rossman, 2011). Sample inclusion criteria included anyone who was dependent on a wheelchair (no facilitators), and filtering criterion was whether they had visited a spa or not.

Questions to participants were informed based on literature, and particularly influenced by similar studies by authors such as Rachid-Kandvani et al. (2015) as the customer journey a dental patient takes resembles that of which a spa guest would take (i.e. both environments require transfer to a treatment couch, and both can be classed as vulnerable situations). The questions covered the entire spa customer journey, from the initial search for suitable premises and first contact with its staff, physical arrival at the organisation, through to any

service recovery on departure. Whether the participant had visited a spa or not determined which questions they would be asked; those who had not visited were questioned as to why this was, and those who had visited a spa were questioned in more detail about their experiences. Questions were asked via online and telephone interviews, and where this was not practical for the participant, they were emailed interview questions to fill out at their own convenience, as well as any follow up questions as required by the researcher. Data was analysed using thematic analysis, which allowed key and sub themes to be identified.

## FINDINGS AND DISCUSSION

### Sample Profile

A total of nine participants were recruited for the study, three were known to the researcher, four were recruited via snowball sampling, one via an appeal via self-selection via email to a disability organisation, and one through social media. Participants varied in the severity of their mobility impairment, ranging from those who were able to walk short distances, to those who were completely wheelchair dependent. The reason for mobility impairment and subsequent wheelchair use also varied from advanced neurological disease, to old age. Four of the participants had not visited a spa, and five had visited. The sample profile is shown in Table 3:

*Table 3. Sample profile*

| Participant | Gender | Age | Has/has not visited a spa | Reason for wheelchair use | Mobility capabilities |
|---|---|---|---|---|---|
| P1 | F | 35 | Has | Myalgic Encephalomyelitis (M.E.) Postural orthostatic tachycardia syndrome (POTS) | Can only walk short distances |
| P2 | F | 24 | Has | Myalgic Encephalomyelitis (M.E.) | Can only walk short distances |
| P3 | M | 41 | Has | Cerebral palsy | Can only walk short distances |
| P4 | F | 60 | Has not | Multiple Sclerosis | Cannot walk |
| P5 | F | 34 | Has | Spinal Muscular Atrophy | Cannot walk |
| P6 | F | 38 | Has not | Myalgic Encephalomyelitis (M.E.) | Can only walk short distances |
| P7 | F | 42 | Has | Spinal cord injury | Cannot walk |

| | | | | | |
|---|---|---|---|---|---|
| P8 | F | 26 | Has not | Myalgic Encephalomyelitis (M.E.)<br>Postural orthostatic tachycardia syndrome (POTS)<br>Suffers from seizures | Can only walk short distances |
| P9 | F | 86 | Has not | Old age and arthritis | Can barely walk |

After the data was analysed using thematic analysis, it was possible to rank the barrier types in order of significance for each group of participants, shown in Table 4

*Table 4. Rank of significance of each barrier type for different spa consumers*

| **Rank of significance** | **Non-spa visitors** | **Spa-visitors** |
|---|---|---|
| 1 | Information | Information |
| 2 | Intrinsic | Environmental |
| 3 | Environmental | Social |
| 4 | Social | Intrinsic |

This data shows that barriers hold different levels of significance for different consumer groups. However, the key finding for this study was that information barriers were the most critical barriers for both groups of wheelchair users when accessing the spa industry.

**Understanding The Internal And External Barriers To Participation Wheelchair Tourists Who Have Not Visited A Spa May Face**

*Informational barriers*

These were the most influential barriers to spa participation. As stated in the literature review, wheelchair users rely on accurate information to inform their purchase decision or intention to visit (Kolodziejczak, 2019) and the findings of this study further reinforced this. The study participants all had varying degrees of mobility and severity of their health condition, meaning that all have diverse but specific needs, which they must ensure will be met. The very fact that they cannot just turn up at a spa and hope for the best means a visit requires careful researching of spas in order to gain the relevant information needed in order for them to decide whether to visit it or not.

The research *process to find a suitable spa can be very lengthy and time consuming,* with issues described by participants as being similar to those

experienced when trying to buy concert tickets (Attitude is Everything, 2018; Olsen, 2018). P6 wished to visit a spa - but has had to make several telephone calls in a so far fruitless search to find a suitable one.

This research process is often made harder due *to lack of information*. It is often necessary for wheelchair users to view the spas website or contact the spa itself, in order to determine whether their individual needs will be satisfied, either by asking questions or viewing the available information provided. Here, the study has found that the lack of information from both websites and from spa staff about their own workplace have been a barrier to participation. Vague answers are not enough for someone who is already vulnerable, when wanting to enter an environment that has the potential to make them even more vulnerable. If persons do not feel comfortable talking on the telephone regarding their needs with a disability, websites are therefore the next best information option and are available even when the spa itself is closed. However, participants expressed frustration again at the lack of available information online and a general distrust regarding their accuracy.

These findings are consistent with information barriers found in other industries and sectors; lengthy complicated online searches for suitable premises are also found when searching for an accessible dental practice, often resulting in a wheelchair user giving up the search (Michopoulou & Buhalis, 2013; Rachid-Kandvani et al., 2015). Lack of information on websites and from staff again corresponds with the recent studies on booking concert tickets (Attitude is Everything, 2018; Olsen, 2018) but also reinforces earlier findings from studies on aviation (Chang & Chen, 2012; Davies & Christie, 2017; Poria et al., 2010) hotels (Poria et al., 2011) and when visiting other leisure and tourist attractions (United Nations, 2006c) suggesting it is a widespread and well established problem.

*Intrinsic barriers*

For non-spa visitors, the intrinsic barrier is also highly influential, where wheelchair users own health conditions and associated limitations affect their intention and ability to visit a spa. Participants agreed that some *medical condition makes it very difficult to visit*. For those participants who had more severe mobility impairment such as P4 who has advanced MS, there were concerns they would need special assistance; a worry echoed by P9, an elderly participant who is barely able to walk or stand up unassisted. P8 with specific needs as a result of their complex and fluctuating medical condition was concerned about these not being met, or understood. Finally, three out of the four non-visiting participants felt that visiting a spa would be too much of a struggle overall.

These findings show that intrinsic barriers act as a key barrier to spa participation after information barriers. Some wheelchair users have highly specific individual needs resulting from medical conditions, and require specialist equipment or trained personnel. If these are not available, spa can be considered another environment that is best avoided due to the stress and effort required, and the potential for problems to occur (Yau et al., 2004).

*Environmental (physical) barriers*

Environmental barriers were not always physically experienced; however they were anticipated. Participants expressed concern over *potential inaccessibility of the sites*, and the possibility of architectural obstacles preventing access to the building, and lack of specialist equipment needed, such as hoists. Environmental barriers such as internal steps prevent full and equal participation to spa experiences compared to those who are able bodied, also a negative factor on the intention to visit. In the case of P4, who wishes to visit a spa with friends, the steps or architectural features she was informed about would exclude her from some areas that her friends would enjoy, another example of barriers causing social isolation and exclusion for wheelchair users (Craig, Tran, & Middleton, 2009). This, when combined with all the other barriers was summed up by P8 when she said: *"I would not risk going and spending a lot of money to not feel like I could relax and enjoy the experience the same way able-bodied people can."*

Environmental barriers are found in many other sectors, some identified in table one such as hotels (Poria et al., 2011) dentistry (Rachid-Kandvani et al., 2015) and libraries (Leong & Higgins, 2010) and throughout daily life. It is therefore deemed easier to avoid entering an environment for an activity that can be considered recreational (i.e. not an essential daily activity) where there are more potential obstacles to negotiate.

*Social Barriers*

Social barriers were mentioned by only one of the four non-visiting participants, who explained that she was made to feel that her business was not welcome as a wheelchair user when making initial enquiries with the spa. Negative first impressions of an organisation and its service such as this can be classed as a barrier to participation, particularly in a non-essential service environment such as this, where the consumers can decide to go elsewhere if they receive poor service. What is encouraging is that the other three participants did not mention this, perhaps indicating that this barrier is not as prevalent as others. Although not a medical environment, spa can still be considered a caring environment and should be welcoming to all.

In comparison with the literature on existing disability studies, this experience correlates most closely with those service attitudes expressed in casinos (Wan, 2013) a leisure environment that may lack the higher levels of service training and professionalism from its staff members compared to sectors such as those within healthcare.

## Barriers Encountered By Spa Visitors Using Wheelchairs

This consumer group were most affected by information and environmental barriers, initially struggling to find a spa to visit, and once there, finding that architectural features limited access, leading to a lesser experience than able-bodied people enjoyed; despite paying the same price.

*Informational barriers*

Information barriers were identified as affecting spa visiting wheelchair tourists in similar ways to those who didn't visit, with lack of information from both websites and staff members resulting in a *lengthy and difficult search*. However, information barriers were also experienced once the wheelchair user was in the spa too, with staff not knowing the implications of having certain treatments that had been booked.

Four out of the five spa-visiting participants mentioned a lack of information on websites, as well as staff being unaware of the accessibility of their own workplace. *Lack of information* from staff for these participants was not limited to accessibility, but also included lack of information about the suitability and implications of having certain treatments, which has resulted in one of the participants being refused a pre booked treatment when they arrived at the spa, causing disappointment, distress and embarrassment. Once arrived at the spa, lack of information can also apply to signage of accessible features, such as the entrance, or where the lifts are located.

For those wheelchair tourists visiting a spa, these findings indicate that information barriers are more widespread and are not only limited to the search process. These findings first align with the findings from non-spa users regarding the lengthy search for a spa and gathering information, as well as with the studies in other industries as previously stated in table 1, such as when accessing dental practices (Rachid-Kandvani et al., 2015) and the aviation industry as a consumer (Chang & Chen, 2012; Davies & Christie, 2017). Additionally the lack of knowledge from staff regarding treatment implications echoes the findings of studies of barriers within healthcare environments (Stillman et al., 2017; Tarasoff, 2017). Poor signage to accessible entrances

and lifts were also identified in studies in hotels (Poria et al., 2011), libraries (Leong & Higgins, 2010) and casinos (Wan, 2013).

*Environmental (physical) barriers*

For spa visiting participants, these barriers were inevitably experienced more profoundly than those who had not visited, and were experienced throughout the customer journey through the spa, from the entrance, through to the changing rooms, thermal facilities, treatment rooms and finally the relaxation rooms. Barriers preventing access to the spa building itself were mentioned, correlating with studies on libraries (Leong & Higgins, 2010) and dentistry (Rachid-Kandvani et al., 2015). P1 and P2 mentioned having to use an alternative “tradesman’s entrance” due to *inaccessibility* of the entrance, and this has also been experienced by wheelchair users when visiting casinos (Wan, 2013).

The lack of suitable accessible changing and toilet facilities in spas is a common occurrence again within casinos (Wan, 2013) as well as having prevalence in aviation (Chang & Chen, 2012; Davies & Christie, 2017; Poria et al., 2010; Yau et al., 2004). hospitals (Stillman et al., 2017; Tarasoff, 2017), dental practices (Rachid-Kandvani et al., 2015) and other leisure attractions, with comments that they were either used for other purposes such as being used as a storeroom/cleaning cupboard (P3) or lacking in specialised equipment that would make them accessible for those who require hoists (P5).

Some spa thermal facilities such as saunas and the pool itself were deemed not accessible again due to architectural features such as steps or again, lack of lifting equipment. Narrow doorways and small and cluttered rooms prevent access and manoeuvrability for wheelchairs, as has been identified in dental practices, hotels and casinos (Poria et al., 2011; Rachid-Kandvani et al., 2015; Wan, 2013).

Regarding treatment rooms, narrow doorways either result in total inaccessibility (and means the wheelchair user cannot have a treatment) or lead to the wheelchair user having to leave their chair, leaving them more vulnerable and not at ease, defeating the object of the experience and mirroring similar negative emotions identified in the studies on aviation, where plane aisles are too narrow to fit a standard wheelchair (Chang & Chen, 2012; Davies & Christie, 2017; Poria et al., 2010; Yau et al., 2004). These barriers also occur within the relaxation room, where the beds and beanbags are also inaccessible, whilst furniture arrangements and small dimensions can make manoeuvring a wheelchair very difficult, also expressed in the study of dental practices (Rachid-Kandvani et al., 2015) and healthcare settings (Stillman et al., 2017; Tarasoff, 2017).

Spa environmental barriers at best cause inconvenience for wheelchair users when they require use of a separate entrance, and at their worst cause total lack of access to a facility or room, resulting in a lesser experience than an able bodied person. In the case of P3, difficulties getting onto a treatment bed were the direct cause of their reluctance to book treatments.

*Social barriers*

This type of barriers is the most subjective; participants react and interpret behaviour in different ways and it affects individuals to different degrees. However, there is a negative theme in the participant's experiences that staff have been visibly uncomfortable at serving them, or their body language has made them feel like a burden or an effort, adversely affecting the experience.

Participants discussed *unsolicited staff conduct* and disclosed that they had faced negative attitudes from staff both at reception and in the treatment rooms both by body language and in treatments they have received. This negative conduct has affected the welcome experience at the spa, as well as the experience and atmosphere within the treatment room (P1). P5 had a negative treatment experience and directly stated that she felt it was because of their disability. Negative attitudes from staff have also been experienced in casinos (Wan, 2013) where staff spoke to disabled customers as if they were stupid. Not knowing how to lift or move a wheelchair user, or not feeling confident about performing a treatment on them, can also be blamed on a lack of training, which has been experienced within healthcare settings and aviation, when transferring customers to an airline seat, or medical/dentistry table (Chang & Chen, 2012; Davies & Christie, 2017; Poria et al., 2010, 2011; Rachid-Kandvani et al., 2015; Yau et al., 2004).

*Intrinsic barriers*

Intrinsic barriers have made the least impact for these participants and have not adversely affected the intention to visit, as *medical condition should not cause limited participation*. However, the presence of the intrinsic barriers was identified within this group of participants, as it limited the level of participation that the wheelchair user is able to achieve. For example, P1 was happy to go to a spa, but due to their medical condition, would not visit alone. Other participants do not feel safe using certain facilities at a spa due to their medical condition (P2 and P3)

## CONCLUSION

Following the discussions above it becomes clear that within the spa industry, the able bodied person has been prioritised, mirroring the wider social and built environment (Aitchison, 2003). These findings can help to further strengthen the argument of McKercher and Darcy (2018) who claim that for disabled people overall, barriers are one of the many reasons why participation rates in and qualities of experience of tourism are lower than that of the general population.

This study expanded the existing body of academic knowledge by adding spa to the list of industries where the barriers facing wheelchair users have been investigated. It has identified previously unknown barriers which are experienced and by whom, and how they affect the participation of a wheelchair tourist; it allows a greater understanding of the subject of accessibility, uniquely within a spa context. Findings confirm that the spa industry is also marred with barriers, and has similar issues regarding accessibility with other industries and sectors, particularly those in healthcare and dentistry.

With regards to the ability of the spa industry to service the important and growing market segment of wheelchair tourists it is clear that the able bodied have been prioritised, much like the rest of society and the built environment that follows the medical model of disability. Primary data has shown that wheelchair tourists wish to and do visit spas, however barriers are present throughout their customer journey and adversely affect their participation. Therefore at present, even though the spa industry is serving these consumers, there are improvements to be made.

Hence, the following recommendations are proposed to help industry become more inclusive and accessible. There is a clear need for accurate, reliable and easy to access information, both regarding spa accessibility and the implications of treatments. This was the key barrier for both sets of participants, however it is arguably the most straightforward to remedy, using ICT tools such as websites and social media, and improving their content with precise and up to date accessibility information that takes into account different impairments, not just mobility. Websites should be simple to navigate and information easy to find. Accessibility information should cover all areas of the spa, including any additional areas such as where food is consumed. An example of required information specific to wheelchair users would be how wide the spa treatment room doors are, and if the spa has any lifts.

These technologies have the potential to act as a 24 hour virtual “spa reception” providing a valuable source of instant information - the importance of them should not be underestimated. Photos and even walkthrough videos can add to accessibility information to help add further clarity for a potential visitor, better allowing them to make an informed decision. Access information could also be

detailed on a pdf, which could be attached to an email sent in reply to enquiries from wheelchair users.

Training staff on the accessibility of their own workplace will further add to this, perhaps keeping a manual by the telephone that they can refer to, with door dimensions or step locations and heights clearly stated. The language that staff use when serving not just wheelchair users, but all disabled people can also be improved, as was highlighted by the presence of the social barrier. This can be achieved via specialist training programmes.

Finally, the prevalence of environmental (physical) barriers throughout spas shows that for wheelchair users, they are sometimes not the relaxing and stress relieving places they market themselves as. It is appreciated that spas are often located in old and converted buildings, where drastically improving access is not possible, however simple measures such as acquiring portable ramps will allow a wheelchair to negotiate single steps, and ensuring that treatment rooms have adjustable couches is also important, as this eases the process of transfer from wheelchair to treatment couch.

Spas of the future should be designed with a variety of users in mind, not just wheelchair users but those with other impairments too. Every aspect of the customer journey should be considered, from the entrance through to the changing rooms, thermal facilities and treatment rooms. This includes the dimensions of rooms, width of doors and corridors, as well the installation or provision of specialist equipment such as hoists. This equipment may not be aesthetically pleasing, however portable hoists are available and can easily be stored in a cupboard (PN-Paraplegia News, 2005).

These recommendations are intended to improve the service that the spa industry provides for wheelchair tourists, in order to increase participation and elevate the spa experience. Better experiences may result in positive word of mouth recommendations, encouraging more wheelchair users to visit. Additionally, as a result of these recommendations, non-spa visitors may feel better reassured that they can participate in spa, lessening the limiting effects of their own intrinsic barriers. By becoming more accessible, spas can take both a social and economic advantage over their competitors, increasing their sustainability.

**Limitations Of Study And Future Research Directions**

As with all research this study also has inherent limitations. The number of participants was limited, and a bigger sample should be used in the future to corroborate the findings. Also, future research should look into more detail into the requirements generated by different levels of motor dis/ability. For example,

a set of stairs may be a challenge for someone who is able to walk, albeit with difficulty, and uses a wheelchair for convenience and speed, however it would be practically impossible for someone who is totally paralysed to negotiate them. With this in mind, it is recommended that further studies concentrate on those with more similar levels of impairment, in order to further investigate specific needs. This research concentrated on mobility impairment, however other sensory or cognitive impairments should also be investigated, as these people may face different barriers than the ones identified for wheelchair users here, or the same barriers but with different implications.

## REFERENCES


Aitchison, C. (2003). From leisure and disability to disability leisure: developing data, definitions and discourses. *Disability & Society, 18*(7), 955-969.

Ambrose, I., Darcy, S., & Buhalis, D. (2012). *Best Practice in Accessible Tourism: Inclusion, Disability, Ageing Population and Tourism.* UK: Channel View Publications.

Attitude is Everything. (2018). *State of Access Report 2018.* Available at: http://www.attitudeiseverything.org.uk/uploads/general/State_of_Access_Report_2018.pdf

Beck, M. (2010). *Theory and Practice of Therapeutic Massage.* 5th edn. USA: CENGAGE Learning.

Bogart, K. R., Rottenstein, A., Lund, E. M., & Bouchard, L. (2017). Who self-identifies as disabled? An examination of impairment and contextual predictors. *Rehabilitation Psychology*, *62*(4), 553–562.

Borges Tiago, M., Couto, J., Tiago, F., & Dias Faria, S. (2016). Baby Boomers turning grey: European profiles, *Tourism Management, 54*, 13-22.

Bryman, A. (2016). *Social Research Methods.* 5th edn. UK: Oxford University Press.

Buhalis, D., & Darcy, S. (2011). *Accessible Tourism.* UK: Channel View Publications.

Buhalis, D., & Michopoulou, E. (2011). Information-Enabled Tourism Destination Marketing: Addressing the Accessibility Market, *Current Issues in Tourism, 14*(2), 145-168.

Chang, F., Wang, Y., Jang, Y., & Wang, C. (2012). Factors Associated With Quality of Life Among People With Spinal Cord Injury: Application of the International Classification of Functioning, Disability and Health Model. *Archives of Physical Medicine and Rehabilitation. 93*(12), 2264-2271.

Chang, Y., & Chen, C. (2012). Meeting the needs of disabled air passengers: Factors that facilitate help from airline and airports, *Tourism Management, 33*, 529-536.

Charlier, R., & Chaineux, M. (2009). The healing sea: A sustainable coastal ocean resource: Thalassotherapy, *Journal of Coastal Research, 25*(4), 838-856.

Clift, S., & Page, S. (1996). *Health And The International Tourist.* 1st edn. UK: Routledge.

Craig, A., Tran, Y., & Middleton, J. (2009). Psychological morbidity and spinal chord injury: a systematic review. *Spinal Cord, 47*(2), 108-114.

Crismariu, O. (2017). Accessible Tourism – An Expression of Social Responsibility. *Cactus*, *2*, 33.

Darcy, S. & Dickson, T. (2009). A whole-of-life approach to tourism: The case for accessible tourism experiences. *Journal of Hospitality and Tourism Management, 16*(1), 32-44.

Davies, A., & Christie, N. (2017). An exploratory study of the experiences of wheelchair users as aircraft passenger – implications for policy and practice. *IATSS Research*, *4*(2), 89-93.

Devile, E., & Kastenholz, E. (2017). Accessible tourism experiences: the voice of the people with visual disabilities. *Journal of Policy Research in Tourism, Leisure and Events, 10*(3), 265-285.

Domingos, T., & Braga, E. (2014). Meaning of aromatherapy massage in mental health. *Acta Paulista De Enfermagem, 27*(6), 579-584.

Gass, E., & Gass, G. (2001). Thermoregulatory responses to repeated warm water immersion in subjects who are paraplegic. *Spinal Cord*, *39*(3), 149-155.

Global Wellness Institute. (2018a). *Global Wellness Economy Monitor – October 2018.* Available at: https://globalwellnessinstitute.org/wp-content/uploads/2019/04/GWIWellnessEconomyMonitor2018_042019.pdf

Global Wellness Institute. (2018b). *Global Wellness Tourism Economy – November 2018.* Available at: https://globalwellnessinstitute.org/industry-research/global-wellness-tourism-economy/

Global Wellness Summit. (2019). *2019 Wellness Trends.* Available at: https://www.globalwellnesssummit.com/2019-global-wellness-trends/download-report/

Gomez, C., Carretero, M., Maraver, F., Cantista P., Armijo, F., Legido, J., … Delgado, R. (2013). Peloids and Pelotherapy: Historical Evolution, classification and glossary. *Applied Clay Science*, *75-76*, 28-38.

Gray, D., Gould, M., & Bickenbach, J. (2003). Environmental barriers and disability. *Journal of Architectural And Planning Research, 20*(1), 29-37.

Gutenbrunner, C., Bender, T., Cantista, P., & Karagulle, Z. (2010). A proposal for a worldwide definition on health resort medicine, balneotherapy, medical hydrology and climatology. *International Journal of Biometeorology*, *54*(5), 495-507.

Haegele, J., & Hodge, S. (2016). Disability Discourse: Over view and Critiques of the Medical and Social Models. *Quest* (00336297) *68*(2), 193-206.

Hammerle, J. (2005). The rise of stadium seating in movie theatres and the disabled's fight for a comparable seat. *DePaul Law Review* 2, 589.

Harpur, P., Connolly, U., & Blanck, P. (2017). Socially Constructed Hierarchies of Impairments: The Case of Australian and Irish Workers' Access to Compensation for Injuries. *Journal of Occupational Research, 27*(4), 507-519.

Harris, F., Yang, H., & Sanford, J. (2015). Physical Environmental Barriers to Community Mobility in Older and Younger Wheelchair Users. *Topics in Geriatric Rehabilitation, 31*(1), 42-51.

Hattan, A. (2004). Stadium-Style Seating Movie Theatres: Does the Cornerstone of the Theatre Industry's Recent Transformation Violate the Americans with Disabilities Act? *Seton Hall Journal of Sports & Entertainment Law, 14*(1), 267-303.

Hudson, S., Thal, K., Cardeas, D., & Meng, F. (2017). Wellness tourism: stress alleviation or indulging healthful habits? *International Journal of Culture, Tourism, and Hospitality Research, 11*(1), 35-52.

Hung, K., & Lu, J. (2016). Active living in later life: An overview of aging studies in hospitality and tourism journals. *International Journal of Hospitality Management, 53*, 133-144.

Hung, K., & Petrick, J. (2009). How Do We Get Baby Boomers And Future Seniors On Motorcoaches? *Tourism Analysis 14*(5), 665-675.

Jackson, E., & Searle, M. (1985). Recreation Non-Participation And Barriers To Participation: Concepts, And Models*. Loisir et Societe / Society and Leisure, 8*(2), 693-707.

Jackson, M. (2018). Models of Disability and Human Rights: Informing the Improvement of Built Environment Accessibility for People with Disability at Neighborhood Scale? *Laws 7*(1), 10.

Johnson, J. (2011). *Deep Tissue Massage*. UK: Human Kinetics.

Johnson-Migalski, L., & Drout, M. O. (2018). Using the International Classification of Functioning, Disability, and Health (ICF) in Adlerian approaches. The Journal of Individual Psychology, 74(1), 38–54.

Kaganek, K., Ambrozy, T., Mucha, D., Jurczak, A., Bornikowska, A., Ostrowski, A., … Mucha, T. (2017). Barriers To Participation In Tourism In The Disabled. *Sport Tourism, 24*, 121-129.

Karagulle, M., & Karagulle, M. (2015). Effectiveness of balneotherapy and spa therapy for the treatment of chronic low back pain: a review on latest evidence. *Clinical Rheumatology, 34*(2), 207-214.

Kasnauskiene, G., & Michnevic, K. (2017). Contribution of increased life expectancy to economic growth: evidence from CEE countries*. International Journal of Economic Sciences 2,* 82.

Kastenholz, E., Eusebio, C., & Figueiredo, E. (2015). Contributions of tourism to social inclusion of persons with disability. *Disability & Society 30*(8), 1259-1281.

Keeratitanont, K., Jensen, M., Chatchawan, U., & Auvichayapat, P. (2015). The efficacy of traditional Thai massage for the treatment of chronic pain: A systematic review. *Complementary Therapies in Clinical Practice*, *22*, 26-32.

Kim, E., Chiange, L., & Tang, L. (2016). Investigating wellness tourists' motivation, engagement and loyalty: in search of the missing link. *Journal of Travel & Tourism Marketing, 34*(7), 867-879.

Kolodziejczack, A. (2019). Information As A Factor Of The Development Of Accessible Tourism For People With Disabilities. *Quaestiones Geograhicae, 2*, 67.

Koog, Y., Jin, S., Yoon, K., & Min, B. (2010). Interventions for hemiplegic shoulder pain: Systematic review of randomised controlled trials. *Disability and Rehabilitation, 32*(4), 282-291.

Leong, I., & Higgins, S. (2010). Public Library Services For Wheelchair-Bound Young People in Singapore. *Public Library Quarterly*, *29*(3), 210-229.

Liu, P., Zhang, H., Zhang, J., Sun, Y., & Qiu, M. (2019) Spatial-temporal response patterns of tourist flow under impulse pre-trip information search: From online to arrival. *Tourism Management. 73,* 105-114.

Marshall, C., & Rossman, G. (2011) *Designing Qualitative Research.* 5th edn. USA:SAGE Publications Inc.

Masala, C., & Petretto, D. (2008). From disablement to enablement: Conceptual models of disability in the 20th Century. *Disability & Rehabilitation, 30*(17), 1233.

McKercher, B., & Darcy, S. (2018). Re-conceptualizing barriers to travel by people with disabilities. *Tourism Management Perspectives*, *26,* 59-66.

Michopoulou, E. (2017) 'Marketing for the Spa Industry' in Rawlinson, S. and Heap, T. (eds). *International Spa Management.* Oxford: Goodfellow Publishers.

Michopoulou, E., & Buhalis, D. (2013) Information Provision for Challenging Markets: The Case of the Accessibility Requiring Market in the Context of Tourism, *Information and Management*, *50*(5), 229-239.

Michopoulou, E., Darcy, S., Ambrose, I., & Buhalis, D. (2015), Accessible tourism futures: the world we dream to live in and the opportunities we hope to have, *Journal of Tourism Futures*, *1*(3), 179-188.

Mintel. (2015). *Complementary and Alternative Medicine – UK – December 2015.* Available at: https://academic.mintel.com/display/716196/

Morris, J., Mueller, J., & Jones, M. (2010). Tomorrows Elders with Disabilities: What the Wireless Industry Needs to Know. *Journal of Engineering Design, 21*(2/3), 131-146.

Nyanjom, J., Boxall, K., & Slaven, J. (2018). Towards inclusive tourism? Stakeholder collaboration in the development of accessible tourism. *Tourism Geographies, 20*(4), 675-697.

Olsen, J. (2018). Socially disabled: the fight disabled people face against loneliness and stress. *Disability & Society, 33*(7), 1160-1164.

Ortega, E., Galvez, I., Hinchado, M,. Guerro, J., Martin-Cordero, L., & Torres-Piles, S. (2017). Anti-inflammatory effect as a mechanism of effectiveness underlying the clinical benefits of Pelotherapy in osteoarthritis patients: regulation of the altered inflammatory and stress feedback response. *International Journal of Biometeorology, 61*(10), 1777-1785.

Ozkuk, K., Uysal, B., Ates, Z., Okmen, B., Refia, S., & Gamze, D. (2018). The effects of inpatient versus outpatient spa therapy on pain, anxiety, and quality of life in elderly patients with generalized osteoarthritis: a pilot study. *International Journal Of Biometeorology, 62*(10), 1823-1832.

Peamruetai, B., Khunnara, N., Angkana, A., Sukree, K., Suton, J., Premsuda, J., … Pravit, A. (2016). The Effect of the Posture of the ”Hermit Doing Body Contortion” on Relief of Shoulder and Scapular Pain Caused by Chronic Myofascial Pain Syndrome: A Randomised, Parallel Group, Controlled Trial. *Siriraj Medical Journal, 68*(6), 350-357.

Pereira, L. (2018). Seaweeds as Source of Bioactive Substances and Skin Care Therapy – Cosmeceuticals, Algotherapy and Thalassotherapy. *Cosmetics, 5*(4), 68.

PN-Paraplegia News. (2005). Pool Party: Why Swelter in Summers Heat? Whether for therapy or just cooling off, residential swimming pools and spas can be accessed by just about everyone. *PN- Paraplegia News, 5*, 55.

Poria, R., Reichel, A., & Brandt, Y. (2010). The Flight Experiences of People with Disabilities: An Exploratory Study. *Journal of Travel Research, 49*(2), 216.

Poria, Y., Reichel, A., & Brandt, Y. (2011). Dimensions of hotel experience of people with disabilities: an exploratory study. *International Journal of Contemporary Hospitality and Management*, *23*(5), 571–591.

Rachid-Kandvani, F., Nicolau, B., & Bedos, C. (2015). Access to Dental Services for People Using a Wheelchair. *American Journal of Public Health, 105*(11), 2312-2317.

Rawlinson, S., & Heap, T. (2017). *International Spa Management: Principles and practice.* UK: Goodfellow Publishers Ltd.

Smith, E., Sakakibara, B., & Miller, W. (2016). A review of factors influencing participation in social and community activities for wheelchair users. *Disability & Rehabilitation: Assistive Technology, 11*(5), 361-374.

Smith, M., & Puczko, L. (2017). *The Routledge Handbook of Health Tourism.* UK: Routledge.

Smith, R. (1987). Leisure of disable tourists*. Annals of Tourism Research, 14*(3), 376-389.

Sritoomma, N., Moyle, W., Cooke, M., & O'Dwyer, S. (2012). The effectiveness of Swedish massage and traditional Thai massage in treating chronic low back pain: A review of the literature. *Complementary Therapies in Clinical Practice, 18*(4), 227-234..

Stillman, M., Williams, S., Bertocci, G., Smalley, C., & Frost, K. (2017). Healthcare utilization and associated barriers experienced by wheelchair users: A pilot study. *Disability And Health Journal, 10*(4), 502-508.

Suarez, M., Gonzalez, P., Dominguez, R., Bravo, A., Melian, C., Perez, M., Fagundo, J. (2011). Identification of organic compounds in San Diego de los Banos Peliod (Pinar del Rio, Cuba)*. Journal of Alternative and Complementary Medicine, 17*(2), 155-165.

Tarasoff, L. (2017). Sexual and Reproductive Health of Women with Disability: "We don't know. We've never had anybody like you before. Barriers to perinatal care for women with physical disabilities*. Disability and Health Journal, 10*, 426-433.

Tsiotsou, R., & Hudson, S. (2010). Wooing zoomers: marketing to the mature traveller. *Marketing intelligence & Planning, 28*(4), 444-461.

Ucok, K., Mollaoglu, H., Demirel, R., Ucok, K., Mollaoglu, H., Kavuncu, V., … Evcik, D. (2008). Effects of balneotherapy with exercise in patients with low back pain. *Journal of Back and Musculoskeletal Rehabilitation*, *21*(4), 263-272.

United Nations. (2006a). *Convention on the Rights of Persons with Disabilities – Articles.* Convention on the Rights of Persons with Disabilities (CRDP). Available at: https://www.un.org/development/desa/disabilities/convention-on-the-

rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

United Nations. (2006b). *Article 19 – Living independently and being included in the community.* Convention on the Rights of Persons with Disabilities (CRDP). Available at: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-19-living-independently-and-being-included-in-the-community.html

United Nations. (2006c). Article 30 – Participation in cultural life, recreation, leisure and sport. *Convention on the Rights of Persons with Disabilities (CRDP).* Available at: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-30-participation-in-cultural-life-recreation-leisure-and-sport.html

Varga, J., Gaal, J., Varga, J., Szekanecz, Z., Kurko, J., Ficzere, A., … Bender, T. (2008). Balneotherapy in elderly patients: Effect on pain from degenerative knee and skin conditions and on quality of life. *Israel Medical Association Journal*, *10*(5), 365-369.

Visit England. (2015). *The Purple Pound. Volume and Value of Accessible Tourism in England.* Available at: https://www.visitbritain.org/sites/default/files/vb-corporate/Documents-Library/ve_purplepound2015.pdf

Voigt, C., & Pforr, C. (2014). *Wellness Tourism – A destination perspective.* UK: Routledge.

Voigt, C., Brown, G., & Howat, G. (2011). Wellness tourists: In search of transformation. *Tourism Review, 66*(1), 16-30.

Wan, Y. (2013). Barriers for people with disabilities in visiting casinos. *International Journal of Contemporary Hospitality Management, 25*(5), 660-682.

Weiermair, K., & Mathies, C. (2004). *The Tourism and Leisure Industry: Shaping the Future.* USA: The Haworth Press, Inc.

Williams, V. (2017). The 'Purple Pound' and Breaking down Barriers in the Workplace in the UK. *International Journal of Therapy and Rehabilitation, 24*(3), 97.

World Health Organisation. (2017). *10 facts on disability.* Available at: https://www.who.int/features/factfiles/disability/en/ .

Yau, M., McKercher, B., & Packer, L. (2004). Traveling with a disability. *Annals of Tourism Research, 31*(4), 946-960.

Zhang, Y., Roxburgh, R., Huang, L., Parsons, J., & Davies, T. (2014). The effect of hydrotherapy treatment on gait characteristics of hereditary spastic paraperesis patients. *Gait & Posture*, *39*(4), 1074-1079.

## KEY TERMS AND DEFINITIONS

**Accessibility:** the practice of making products and services, spaces, information, and processes usable by as many people as possible

**Barrier:** a circumstance or obstacle that prevents movement or access

**Disability:** a physical or mental condition that limits a person's movements, senses, or activities

**Leisure:** time when one is not working or occupied; free time

**Spa:** a commercial establishment offering health and beauty treatment through such means as steam baths, exercise equipment, and massage.

**Wellbeing:** the state of being comfortable, healthy, or happy

**Wellness:** the state of being in good health, especially as an actively pursued goal